		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023390

Facility Name: ST ANN'S HEALTHCARE CENTER

Address: 770 STATE STREET (Number) CHESTER (City) 62233 (Zip Code)

County: RANDOLF

Telephone Number: 618-826-2314 **Fax #** 618-826-2316

IDPA ID Number: 37-1023098001

Date of Initial License for Current Owners: 03-01-77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DAVE REIS **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01-01-00 to 12-31-00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) WDM COMPUTER INC. 1900 HARRISON ST QUINCY,IL
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	32	Skilled (SNF)	32	11,712	1
2		Skilled Pediatric (SNF/PED)			2
3	87	Intermediate (ICF)	87	31,842	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,423	1,372	1,488	7,283	8
9	SNF/PED					9
10	ICF	17,585	9,824		27,409	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,008	11,196	1,488	34,692	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.65%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 03-01-77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 1,488

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2000 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	156,658	16,794	10,838	184,290		184,290		184,290			1
2	Food Purchase		163,525		163,525	(2,990)	160,535	(7,829)	152,706			2
3	Housekeeping	69,249	17,907		87,156		87,156		87,156			3
4	Laundry	63,471	23,210		86,681		86,681		86,681			4
5	Heat and Other Utilities			98,215	98,215		98,215		98,215			5
6	Maintenance	48,684	19,075	34,070	101,829		101,829	(300)	101,529			6
7	Other (specify):*											7
8	**TOTAL General Services**	338,062	240,511	143,123	721,696	(2,990)	718,706	(8,129)	710,577			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,042,512	79,653	3,999	1,126,164		1,126,164	(6,079)	1,120,085			10
10a	Therapy	86,373		8,837	95,210		95,210		95,210			10a
11	Activities	35,518	10,405	10,683	56,606		56,606		56,606			11
12	Social Services	32,789	1,031	1,644	35,464		35,464		35,464			12
13	Nurse Aide Training											13
14	Program Transportation		2,766		2,766		2,766		2,766			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,197,192	93,855	25,163	1,316,210		1,316,210	(6,079)	1,310,131			16
	C. General Administration											
17	Administrative	53,383		100,298	153,681		153,681	(24,481)	129,200			17
18	Directors Fees											18
19	Professional Services			22,322	22,322		22,322	2,217	24,539			19
20	Dues, Fees, Subscriptions & Promotions			25,919	25,919		25,919	(16,359)	9,560			20
21	Clerical & General Office Expenses	49,477	10,957	11,147	71,581		71,581	47,023	118,604			21
22	Employee Benefits & Payroll Taxes			180,173	180,173	2,990	183,163	11,881	195,044			22
23	Inservice Training & Education			1,073	1,073		1,073		1,073			23
24	Travel and Seminar			4,635	4,635		4,635	58	4,693			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			31,243	31,243		31,243	7	31,250			26
27	Other (specify):* SALES TAX			3,605	3,605		3,605	(3,605)				27
28	**TOTAL General Administration**	102,860	10,957	380,415	494,232	2,990	497,222	16,741	513,963			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,638,114	345,323	548,701	2,532,138		2,532,138	2,533	2,534,671			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER #0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			75,027	75,027		75,027	(6,537)	68,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			85,838	85,838		85,838	(47)	85,791			32
33	Real Estate Taxes			27,526	27,526		27,526		27,526			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,697	4,697		4,697	(4,697)				35
36	Other (specify):* **STATE TAX**			2,296	2,296		2,296	(2,296)				36
37	**TOTAL Ownership**			195,384	195,384		195,384	(13,577)	181,807			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		2,765		2,765		2,765		2,765			38
39	Ancillary Service Centers		99,662		99,662		99,662	(6,897)	92,765			39
40	Barber and Beauty Shops		7,396		7,396		7,396		7,396			40
41	Coffee and Gift Shops		8,899	5,664	14,563		14,563		14,563			41
42	Provider Participation Fee			65,332	65,332		65,332		65,332			42
43	Other (specify):* **BAD DEBTS**			5,418	5,418		5,418	(5,418)				43
44	**TOTAL Special Cost Centers**		118,722	76,414	195,136		195,136	(12,315)	182,821			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,638,114	464,045	820,499	2,922,658		2,922,658	(23,359)	2,899,299			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,829)	2		4
5	Telephone, TV & Radio in Resident Rooms	(222)	21		5
6	Rented Facility Space	(300)	6		6
7	Sale of Supplies to Non-Patients	(6,079)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,503)	30		9
10	Interest and Other Investment Income	(830)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,605)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,418)	43		24
25	Fund Raising, Advertising and Promotional	(16,667)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,296)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PHARMACY BILLING	(6,897)	42		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,646)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	35,287		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 35,287		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (23,359)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ST ANN'S HEALTHCARE CENTER

ID# 0023390

Report Period Beginning: 01-01-00

Ending: 12-31-00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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27				27
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64				64
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66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 **Report Period Beginning:** 01-01-00 **Ending:** 12-31-00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,829)	0	0	0	0	0	0	0	0	0	0	(7,829)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(300)	0	0	0	0	0	0	0	0	0	0	(300)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,129)	0	0	0	0	0	0	0	0	0	0	(8,129)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,079)	0	0	0	0	0	0	0	0	0	0	(6,079)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(6,079)	0	0	0	0	0	0	0	0	0	0	(6,079)	16
	C. General Administration													
17	Administrative	0	(9,058)	(15,423)	0	0	0	0	0	0	0	0	(24,481)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	479	1,738	0	0	0	0	0	0	0	0	2,217	19
20	Fees, Subscriptions & Promotions	(16,667)	0	308	0	0	0	0	0	0	0	0	(16,359)	20
21	Clerical & General Office Expenses	(222)	41,854	5,391	0	0	0	0	0	0	0	0	47,023	21
22	Employee Benefits & Payroll Taxes	0	7,236	4,645	0	0	0	0	0	0	0	0	11,881	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	58	0	0	0	0	0	0	0	0	58	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7	0	0	0	0	0	0	0	0	0	7	26
27	Other (specify):*	(3,605)	0	0	0	0	0	0	0	0	0	0	(3,605)	27
28	**TOTAL General Administration**	(20,494)	40,518	(3,283)	0	0	0	0	0	0	0	0	16,741	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,702)	40,518	(3,283)	0	0	0	0	0	0	0	0	2,533	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 **Report Period Beginning:** 01-01-00 **Ending:** 12-31-00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,503)	1,966	0	0	0	0	0	0	0	0	0	(6,537)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(830)	783	0	0	0	0	0	0	0	0	0	(47)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(4,697)	0	0	0	0	0	0	0	0	0	(4,697)	35
36	Other (specify):*	(2,296)	0	0	0	0	0	0	0	0	0	0	(2,296)	36
37	**TOTAL Ownership**	(11,629)	(1,948)	0	0	0	0	0	0	0	0	0	(13,577)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(5,418)	0	0	0	0	0	0	0	0	0	0	(5,418)	43
44	**TOTAL Special Cost Centers**	(5,418)	0	0	0	0	0	0	0	0	0	0	(5,418)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(51,749)	38,570	(3,283)	0	0	0	0	0	0	0	0	(16,462)	45

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROGER & DIXIE RICHARD	26.0	ST. ANN'S HEALTHCARE	CHESTER	RDR MGMT	ALBERS	MGMT
BLAIN RICHARD	24.0	ST. ANN'S HEALTHCARE	CHESTER			
BLAIN RICHARD	25.0	CLINTON MANOR	NEW BADEN			
MIKE & GAIL GREER	100	O'FALLON HEALTHCARE	O'FALLON	GREER MGMT	TRENTON	MGMT
MIKE & GAIL GREER	50	ST. ANN'S HEALTHCARE				
MIKE & GAIL GREER	25.0	CLINTON MANOR	NEW BADEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	COMPUTER EQUIP	$ 4,697	RDR MGMT		$	$ (4,697)	1
2	V	32	INTEREST				783	783	2
3	V	30	DEPRECIATION				1,966	1,966	3
4	V	17	MANAGEMENT	50,149	RDR MGMT		41,091	(9,058)	4
5	V	21	CLERICAL		RDR MGMT		41,091	41,091	5
6	V	19	LEGAL/ACCOUNTING		RDR MGMT		479	479	6
7	V	26	INSURANCE		RDR MGMT		7	7	7
8	V	21	OFFICE EXP		RDR MGMT		763	763	8
9	V	22	PAYROLL TAXES		RDR MGMT		7,236	7,236	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 54,846			$ 93,416	$ * 38,570	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT	$ 50,149	GREER MGMT		$ 34,726	$ (15,423)	15
16	V	21	CLERICAL		GREER MGMT		4,393	4,393	16
17	V	22	PAYROLL TAXES/MEALS		GREER MGMT		4,645	4,645	17
18	V	20	DUES & SUBSCRIBTIONS		GREER MGMT		308	308	18
19	V	21	OFFICE EXP		GREER MGMT		998	998	19
20	V	19	LEGAL/PROFESSIONAL		GREER MGMT		1,738	1,738	20
21	V	24	SEMINARS		GREER MGMT		58	58	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,149			$ 46,866	$ * (3,283)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	ROGER RICHARD	PRES	WORK OFCR	26.00	ST . ANN'S	10	25.00		$		1
2	BLAIN RICHARD	SEC	WORK OFCR	24.00	ST . ANN'S	20	50.00				2
3	MIKE GREER	V.PRES	WORK OFCR	50.00	ST . ANN'S	8	20.00				3
4	MIKE GREER	PRES	O'FALLON	100.00		10	25.00				4
5	ROGER RICHARD	MGMT CO	RDR MGMT		ST . ANN'S	20	50.00	MGMT	50,149	17-3	5
6	MIKE GREER	MGMT CO	GREER MGMT		ST . ANN'S	10	25.00	MGMT	50,149	17-3	6
7	MIKE GREER	MGMT CO	O'FALLON		90,688	10	25.00	MGMT			7
8	MIKE GREER	GREER MGMT	CLINTON	25.00	30,400	2	5.00	MGMT			8
9	ROGER RICHARD	RDR MGMT	CLINTON		30,400	10	25.00	MGMT			9
10	BLAIN RICHARD	DIRECTOR	CLINTON	25.00	250	20	50.00	DIR FEES			10
11	MIKE GREER	DIRECTOR	CLINTON		250						11
12											12
13								TOTAL	$ 100,298		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: GREER MANAGEMENT
Street Address: 581 COUNTRYSIDE LANE
City / State / Zip Code: TRENTON,IL 62293
Phone Number: (618-224-7715
Fax Number: (618-224-7716

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	MANAGEMENT FEES	171,237	3	$ 118,573	$ 118,573	50,149	$ 34,726	1
2	21	CLERICAL WAGES	MANAGEMENT FEES	171,237	3	15,000	15,000	50,149	4,393	2
3	22	PAYROLL TAXES	MANAGEMENT FEES	171,237	3	14,313		50,149	4,192	3
4	22	MEALS	MANAGEMENT FEES	171,237	3	1,547		50,149	453	4
5	20	DUES & SUBSCRIPTIONS	MANAGEMENT FEES	171,237	3	1,053		50,149	308	5
6	21	POSTAGE	MANAGEMENT FEES	171,237	3	266		50,149	78	6
7	24	SEMINARS	MANAGEMENT FEES	171,237	3	198		50,149	58	7
8	21	OFFICE SUPPLY	MANAGEMENT FEES	171,237	3	1,162		50,149	340	8
9	21	TELEPHONE	MANAGEMENT FEES	171,237	3	1,980		50,149	580	9
10	19	LEGAL	MANAGEMENT FEES	171,237	3	3,185		50,149	933	10
11	19	CONSULANT FEES	MANAGEMENT FEES	171,237	3	2,750		50,149	805	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 160,027	$ 133,573		$ 46,866	25

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RDR MANAGEMENT
Street Address: 5617 ALBERS ROAD
City / State / Zip Code: ALBERS, IL 62215
Phone Number: (618-248-5642
Fax Number: (618-248-5905

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	MANAGEMENT FEES	80,549	2	$ 66,000	$ 66,000	50,149	$ 41,091	1
2	21	CLERICAL	MANAGEMENT FEES	80,549	2	66,000	66,000	50,149	41,091	2
3	19	ACCOUNTING	MANAGEMENT FEES	80,549	2	680		50,149	423	3
4	26	INSURANCE	MANAGEMENT FEES	80,549	2	11		50,149	7	4
5	19	LEGAL	MANAGEMENT FEES	80,549	2	90		50,149	56	5
6	21	OFFICE EXP	MANAGEMENT FEES	80,549	2	566		50,149	352	6
7	21	TELEPHONE	MANAGEMENT FEES	80,549	2	660		50,149	411	7
8	22	PAYROLL TAXES	MANAGEMENT FEES	80,549	2	11,622		50,149	7,236	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 145,629	$ 132,000		$ 90,667	25

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	UNION PLANTERS BANK		X	MORTGAGE	$15,738.00	05-20-95	$ 1,600,000	$ 800,530	05-20-07	7.2500	$ 63,962	1
2												2
3												3
4												4
5												5
	Working Capital											
6	OWNERS	X		CASH FLOW		04-01-98	253,000	253,000	03-01-01	8.0000	20,240	6
7	VILLAGE BANK		X	VAN LOAN	$578.00	12-01-99	27,740	18,173	11-30-04	8.2500	1,636	7
8												8
9	TOTAL Facility Related				$16,316.00		$ 1,880,740	$ 1,071,703			$ 85,838	9
	B. Non-Facility Related*											
10												10
11	INVESTMENT INTEREST										(830)	11
12	ADD INTEREST ON COMP E	X		RDR MGMT							783	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (47)	14
15	TOTALS (line 9+line14)						$ 1,880,740	$ 1,071,703			$ 85,791	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER **#** 0023390 **Report Period Beginning:** 01-01-00 **Ending:** 12-31-00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	16,890	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	27,526	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,636	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	16,890	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	27,526	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	25,586	8
	1996	23,387	9
	1997	25,796	10
	1998	27,414	11
	1999	27,526	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,246 B. General Construction Type: Exterior BRICK Frame WOOD,STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

RESIDENTIAL APARTMENTS 3248 SQ FT 2 FLOORS 4 BEDROOMS
SISTERS HOUSE 2625 SQ FT 2 FLOORS 7BEDROOMS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	103,500	1977	$ 20,000	1
2					2
3	TOTALS	103,500		$ 20,000	3

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1977	1937	$ 404,102	$	20	$	$	$ 404,102	4
5	46		1977	1976	250,000	7,327	33	7,327		182,852	5
6	10		1985	1985	104,150	3,171	33	3,171		49,975	6
7	15		1987	1987	344,144	10,417	33	10,417		139,275	7
8			1991	1991	357,704	11,964	30	11,964		107,462	8
	Improvement Type**										
9	BUILDING IMP			1978	500		8			500	9
10	NEW ROOF			1983	9,450		15			9,450	10
11	BUILDING IMP			1983	4,469		15			4,469	11
12	ELECTRICAL IMP			1985	3,130	36	15	36		3,130	12
13	ROOF REPAIRS			1987	1,830	92	20	92		1,200	13
14	FIRE ALARM			1987	3,900		8			3,900	14
15	OFFICE BUILDING			1985	28,500	1,432	20	1,432		21,937	15
16	NEW ROOF			1989	4,000	270	15	270		2,989	16
17	PARKING LOT			1991	7,708	794	10	794		7,055	17
18	BUILDING IMP			1992	12,806	788	20	788		6,739	18
19	TELEPHONE SYSTEM			1992	10,071		10	1,008	1,008	9,072	19
20	CUBICLE TRACK			1992	6,531	71	8	71		6,531	20
21	LAND IMP			1993	1,897	127	15	127		899	21
22	A/C UNIT			1984	5,625		8			5,625	22
23	BUILDING IMP			1994	45,734	2,685	20	2,685		18,734	23
24	BUILDING IMP			1993	10,012	1,047	10	1,047		7,697	24
25	PAINTING			1995	11,460	1,190	10	1,190		6,796	25
26	ROOF REPAIRS			1995	11,167	561	20	561		3,306	26
27	HANDRAILS			1995	20,700	2,649	8	2,649		15,181	27
28	BOILER			1995	21,690	1,455	15	1,455		7,504	28
29	ELECTRIAL,FIRE ALARM			1997	12,017	1,168	8	1,168		4,066	29
30	NEW ROOF			1999	30,546	1,535	20	1,535		2,432	30
31	NEW ROOF			2000	3,990	67	15	67		67	31
32	A/C UNIT			2000	7,265	763	8	763		763	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,735,098	$ 49,609		$ 50,617	$ 1,008	$ 1,033,708	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 150,739	$ 15,184	$ 17,150	$ 1,966	8	$ 75,184	37
38	Current Year Purchases	16,764	723	723		8	723	38
39	Fully Depreciated Assets	69,769					69,769	39
40								40
41	TOTALS	$ 237,272	$ 15,907	$ 17,873	$ 1,966		$ 145,676	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	85 CHEV BUS	1996	$ 6,000	$	$	$	3	$ 6,000	42
43	FACILITY	92 VAN	1996	8,420				3	8,420	43
44	FACILITY	89 ST WGN	1996	3,250				3	3,250	44
45	ADM AUTO	ADM AUTO	1999		9,511		(9,511)	3		45
46	TOTALS			$ 17,670	$ 9,511	$	$ (9,511)		$ 17,670	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,010,040	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 75,027	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 68,490	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (6,537)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,197,054	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	ADM AUTO	$ 27,739	$ 9,511	$ 9,511	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 27,739	$ 9,511	$ 9,511	57

G. Construction-in-Progress

	Description	Cost	
58	PLANS	$ 3,420	58
59			59
60			60
61		$ 3,420	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 4,697 Description: COMPUTER EQUIP
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				99,662		99,662	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): PHARMACY BILLING								(6,897)	13
14	TOTAL			$		$	$ 99,662		$ 92,765	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER **#** 0023390 **Report Period Beginning:** 01-01-00 **Ending:** 12-31-00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12-31-00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (6,341)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	539,473		3
4	Supply Inventory (priced at FIFO)	30,707		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,118		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 574,957	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,784,937		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	298,767		16
17	Accumulated Depreciation (book methods)	(1,254,651)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 854,053	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,429,010	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 59,213	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	18,173		29
30	Accrued Salaries Payable	78,457		30
31	Accrued Taxes Payable (excluding real estate taxes)	(8,076)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,848		32
33	Accrued Interest Payable	15,420		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 167,035	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,053,530		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,053,530	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,220,565	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 208,445	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,429,010	$	48

***(See instructions.)**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):	233,039	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 233,039	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	87,024	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(113,494)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) RESIDENTIAL DIVISION	1,876	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (24,594)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 208,445	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,901,172	1
2	Discounts and Allowances for all Levels	(116,879)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,784,293	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	73,916	6
7	Oxygen	750	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 74,666	8
	C. Other Operating Revenue		
9	Payments for Education	45	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	9,447	12
13	Barber and Beauty Care	8,390	13
14	Non-Patient Meals	7,829	14
15	Telephone, Television and Radio	222	15
16	Rental of Facility Space	300	16
17	Sale of Drugs	114,003	17
18	Sale of Supplies to Non-Patients	6,079	18
19	Laboratory	3,407	19
20	Radiology and X-Ray	171	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 149,893	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	830	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 830	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,009,682	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	721,696	31
32	Health Care	1,316,170	32
33	General Administration	494,272	33
	B. Capital Expense		
34	Ownership	195,384	34
	C. Ancillary Expense		
35	Special Cost Centers	129,804	35
36	Provider Participation Fee	65,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,922,658	40
41	**Income before Income Taxes (line 30 minus line 40)****	87,024	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 87,024	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,299	2,299	$ 41,123	$ 17.89	1
2	Assistant Director of Nursing	1,431	1,479	23,924	16.18	2
3	Registered Nurses	9,940	10,596	153,889	14.52	3
4	Licensed Practical Nurses	23,405	24,538	283,604	11.56	4
5	Nurse Aides & Orderlies	62,783	66,349	539,972	8.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,877	6,310	86,373	13.69	8
9	Activity Director	1,909	2,037	18,414	9.04	9
10	Activity Assistants	1,957	2,077	17,104	8.23	10
11	Social Service Workers	3,645	3,805	32,789	8.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,922	4,250	36,305	8.54	15
16	Dishwashers	18,161	19,138	120,353	6.29	16
17	Maintenance Workers	4,079	4,143	48,684	11.75	17
18	Housekeepers	8,888	9,552	69,249	7.25	18
19	Laundry	8,396	8,996	63,471	7.06	19
20	Administrator	2,001	2,080	53,383	25.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,272	4,386	49,477	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,965	172,035	$ 1,638,114 *	$ 9.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 2,438	1-3	35
36	Medical Director				36
37	Medical Records Consultant	156	3,474	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	525	10-3	39
40	Physical Therapy Consultant	28	2,162	10A-3	40
41	Occupational Therapy Consultant	5	220	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	183	6,455	10A-3	43
44	Activity Consultant	8	883	11-3	44
45	Social Service Consultant	20	1,644	12-3	45
46	Other(specify)				46
47	RELIGIOUS		9,800	11-3	47
48	COOKS ASSIST ADORERS SISTERS		8,400	1-3	48
49	TOTAL (lines 35 - 48)	607	$ 36,001		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
RICHARD KLUG	ADM		53,383
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,383

B. Administrative - Other

Description	Amount
	$
RDR MGMT	50,149
GREER MGMT	50,149
TOTAL (agree to Schedule V, line 17, col. 3)	$ 100,298
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HERMAN BODEWES	LEGAL	$ 2,103
WDM COMPUTER	DATA PROCESS/ACTG	20,219
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,322

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,477
Unemployment Compensation Insurance	11,907
FICA Taxes	122,552
Employee Health Insurance	21,237
Employee Meals	2,990
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 183,163

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	820
Health Care Worker Background Check	
(Indicate # of checks performed 23)	276
SUBSCRIPTIONS	1,683
ADVERTISING	16,667
ILL HEALTHCARE ASSOC	5,238
ILLSEC OF STATE	466
HCFA	569
Less: Public Relations Expense	( )
Non-allowable advertising	(16,667)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,252

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE ATTACHED LIST	4,635
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,635

**See instructions.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-00 Ending: 12-31-00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER **#** 0023390 **Report Period Beginning:** 01-01-00 **Ending:** 12-31-00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL HEALTHCARE 5238**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,290** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,332**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **2,990** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **7,828**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **50**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: **NO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.